APPENDIX 9
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION HOME HEALTH THERAPY ATTACHMENT (PA/HHTA)

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization.

If other home health services (nursing, aide services) in addition to home health therapy services are to be provided, complete this attachment form, and submit it along with the appropriate forms.

Submit the Prior Authorization Request Form (PA/RF) and the appropriate attachment(s) to the following address:

EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the Prior Authorization Request Form (PA/RF) and/or the Prior Authorization Home Health Therapy Service Attachment (PA/HHTA) may be addressed to EDS' Telephone/Written Correspondence Unit or Prior Authorization Unit by calling the telephone numbers listed in Appendix 2 of Part A of the WMAP Provider Handbook.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's ten-digit Medical Assistance number as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S NUMERICAL AGE
Enter the age of the recipient in numerical form (i.e., 34, 60, 21, etc.).

PROVIDER INFORMATION:

ELEMENT 6 - THERAPIST'S NAME AND CREDENTIALS
Enter the name and credentials of the primary therapist who would be responsible for and participate in home health therapy services for the recipient. If the performing provider would be a certified therapy assistant, enter the name of the certified therapist, who will be physically present at the residence to supervise the certified therapy assistant.

ELEMENT 7 - THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the therapist who would provide the authorized service (performing provider). If the performing provider would be a therapy assistant, enter the Medical Assistance provider number of the supervising therapist. If the therapist does not have a provider and is employed by or under contract to the agency, enter the agency's provider number.

ELEMENT 8 - THERAPIST'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the therapist who would provide the authorized service (performing provider). If the performing provider would be a therapy assistant, enter the telephone number of the supervising therapist.

ELEMENT 9 - REFERRING/PRESCRIBING PHYSICIAN'S NAME
Enter the name of the physician referring/prescribing home health therapy evaluation/treatment.

ELEMENT 10 - REFERRING/PRESCRIBING PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the physician referring/prescribing home health therapy services.

The remaining portions of this attachment are to be used to document the justification of home health therapy services.

1. Complete elements A through H. You may refer to specific sections of your attachments rather than duplicating information; i.e., "Refer to item #3 of therapy evaluation."

2. Attach a copy of the Physician's Plan of Care.

3. Attach a copy of the therapy evaluation.

4. If the request is for a recipient under age 22, attach a copy of the IEP or explain why there is none.

5. Read the Prior Authorization Statement before dating and signing the attachment.

6. Date and sign attachment.

APPENDIX 10
SAMPLE PRIOR AUTHORIZATION
HOME HEALTH THERAPY ATTACHMENT (PA/HHTA)

Mail To:
E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/HHTA

PRIOR AUTHORIZATION HOME HEALTH THERAPY ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	Im	A.	1234567890	67

PROVIDER INFORMATION

(6) THERAPIST'S NAME AND CREDENTIALS	(7) THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) THERAPIST'S TELEPHONE NUMBER
I.M. Performing, P.T.	12345678	(XXX) XXX-XXXX

(9) REFERRING/PRESCRIBING PHYSICIAN'S NAME	(10) REFERRING/PRESCRIBING PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER
I.M. Referring	87654321

A. Provide a brief history pertinent to the service(s) requested:

RECIPIENT ADMITTED TO HOSPITAL 4-15-92 AFTER CVA. DISCHARGED HOME ON 5-1-92 AT INSISTANCE OF WIFE. NURSING HOME PLACEMENT UNACCEPTABLE TO FAMILY. PRIOR TO CVA, RECIPIENT WAS INDEPENDENT IN ADL AND ACTIVE AROUND THE HOUSE, COMMUNITY AND WITH HIS GRANDCHILDREN. RECIPIENT DID HAVE LOW ENDURANCE AND FATIGUE DUE TO COPD.

B. Provide a descripton of the recipient's diagnosis and problems as they pertain to the need for the therapy services requested. Include the date of onset:

RECIPIENT'S HOSPITALIZATION COMPLICATED BY PNEUMONIA. RECIPIENT HAS HISTORY OF LONG STANDING COPD, ASHD, ARTERIOSCLEROSIS. IN 1990 HE HAD MITRAL VALVE REPLACEMENT AND DOUBLE BYPASS SURGERY. IN 1991 HE HAD L RADICAL NECK RESECTION. RECIPIENT COMMUNICATES THROUGH WRITTEN MESSAGES. RECIPIENT ALERT, FEELS FRIGHTENED AND UNSTEADY WHEN AMBULATORY. RECIPIENT CURRENTLY TUBE FED.

(Alternative method of providing a description: Refer to HCFA 485, Elements 11-20.)

C. State therapy history: (Indicate type/date/location for all types of therapy)

	LOCATION	DATE	PROBLEM TREATED
PT	hospital	4-18-92 to 4-30-92	hemiplegia-theraputic exercise ROM, balance activities, ADL.
	home	5-1-92 to present	
OT	hospital	4-18-92 to 4-20-92	hemiplegia - motor skills ADL
SP	home	5-1-92 to present	

D. Indicate the date of initial evaluation: 5-1-92

Supply dates/tests used/results of additional evaluations:
ROM, MMT, ADL, GAIT - 5-1-92. (5-27-92 EVAL SEE SEC. E.)
AAROM WNL ALL EXTREMITIES, EXCEPT AS FOLLOWS: R SHOULDER, FLEX 0-130, ABD 0-120, IR 0-50; L SHOULDER FLEX 120, ABD 0-110, IR 0-30, BILAT KNEES - 5 EXTENSION, ABDUCTION TRANSFERS-MODERATE ASSIST OF ONE. RECIPIENT HAS EXCESSIVE TRUNK EXTENSION, GOOD WEIGHT BEARING R LE. RECIPIENT REQUIRES MIN/MODERATE ASSIST TO COMPLETE ALL BED MOBILITY. MODERATE ASSIST TO AMBULATE BETWEEN TWO FOR 100 FEET TIMES 3. RECIPIENT BECOMES SHORT OF BREATH. HAS POOR BALANCE AND EXCESSIVE TRUNK FLEXION.

E. Describe progress in measurable/functional terms since treatment was initiated or last authorized:
RECIPIENT REMAINS AS ABOVE. RECIPIENT HAS ACTIVE MOVEMENTS IN ALL L LE JOINTS. MOVEMENTS INDEPENDENT, BUT NOT COMPLETELY OF SYNERGY SUPERVISION TO MINIMAL ASSIST TO COMPLETE PIVOT TRANSFERS. RECIPIENT DEMONSTRATES PROPER TECHNIQUE AND WEIGHT SHIFTING FROM SIT TO STAND: BUT CONTINUES TO HAVE EXCESSIVE TRUNK EXTENSION FROM STAND TO SIT. RECIPIENT INDEPENDENT IN BED MOBILITY WITH TACTILE CUEING. GOOD UNSUPPORTED, UNCHALLENGED SITTING BALANCE. RECIPIENT ABLE TO AMBULATE 200 FEET WITH WHEELED WALKER AND SUPERVISION OF ONE FOR OCCASIONAL LOSS OF BALANCE BACKWARDS. GAIT DOES EXHIBIT DECREASED WEIGHT SHIFT TO L, MINIMAL FLEXION IN L LE DECREASED STEP LENGTH ON R, DECREASED FLOOR CLEARANCE WITH INCREASED RETRACTION L HIP.

F. Attach a Plan of Care indicating specific, measurable goals and procedures to meet those goals:

G. Describe rehablitation potential:

EXCELLENT. RECIPIENT HAS MADE EXCELLENT PROGRESS IN THE PAST MONTH WITH 3X WEEK THERAPY. HE IS WELL MOTIVATED AND COOPERATES WITH THERAPY PROGRAM. ANTICIPATE RECIPIENT WILL BE INDEPENDENT IN ADL AND GAIT IF NO COMPLICATIONS OCCUR AND PT CONTINUES WITH HOME HEALTH AIDE CARRY THROUGH.

(Alternative method of describing rehabilitation potential: Refer to Element 22 of HCFA 485.)

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

H. MM/DD/YY
Date

J. M. Requesting
Requesting Provider's Signature

APPENDIX 11
INSTRUCTIONS FOR COMPLETION OF THE PRIOR AUTHORIZATION AMENDMENT FORM

(1)	DATE	Enter today's date in MM/DD/YY format.
(2)	PREVIOUS PA #	Enter the seven-digit prior authorization request number from the PA/RF form to be amended. The request number is located at the top center section of the PA/RF form.
(3)	RECIPIENT NAME	Enter the recipient's name as indicated in element 3 on the PA/RF form.
(4)	RECIPIENT MA #	Enter the ten-digit recipient Medical Assistance identification number as indicated on the PA/RF form.
(5)	PROVIDER NAME	Enter the billing provider name and address as indicated in element 7 AND ADDRESS on the PA/RF form.
(6)	PROVIDER #	Enter the eight-digit billing provider number as indicated in element 9 on the PA/RF form.
(7)	AMENDMENT EFFECTIVE DATE	Enter the dates that the requested amendment should start ("FROM") and end ("END").
(8)	REASON(S) FOR AMENDMENT REQUEST	Enter the reason(s) for requesting additional service(s) for the recipient. When service is being reduced or discontinued, please clearly indicate the type of service and the date the service is being reduced or discontinued.
(9)	PROCEDURE CODES	Enter the appropriate procedure code and hours per day, days per week, multiplied by the number of weeks for each service. Show only the additional services being requested, not the revised total of services being requested.
(10)	SIGNATURE/DATE	The signature of the provider requesting this amendment and the date of the request must appear in this element.

NOTE: All amendments must include a copy of the new HCFA 486 ordering the changed services and a copy of the PA/RF to be amended. Send the amendment request to:

EDS
Attn: Prior Authorization Unit
6406 Bridge Road, Suite 88
Madison, WI 53784-0088

APPENDIX 12
SAMPLE PRIOR AUTHORIZATION AMENDMENT FORM

WMAP PRIOR AUTHORIZATION AMENDMENT REQUEST

MAIL TO:

EDS
Prior Authorization Unit
6406 Bridge Road, Suite 88
Madison, WI 53784-0088

1. Complete this form.
2. Attach to PA/RF (Prior Authorization Request Form).
3. Attach copy of physician's orders dated within 90 days.
4. Mail to EDS.

1) Date:	2) Previous Prior Authorization Number:	
MM/DD/YY	7654321	
3) Recipient Name:	**4) Recipient Medical Assistance ID Number:**	
Recipient, Ima A.	1234567890	
5) Billing Provider Name and Address:	**6) Billing Provider Number:**	**7) Amendment Effective Date**
I.M. Billing 1 W. Williams Anytown, WI 55555	87654321	**FROM:** 05/11/92 **TO:** 05/13/92

8) Reason(s) for Amendment Request:

Primary care giver (recipient's mother) became ill and could not provide the care needed to get recipient up, dressed, and off to school.

9) Indicate procedure(s) to be amended by hours per day, days per week, multiplied by the number of weeks.

RN _____

LPN _____

HHA HHA initial visit - W9931 - 1 visit per day x 3 days = 3 visits

PT _____

OT _____

ST _____

PCW _____

OTHER _____

10) I. M. Requesting, RN — MM/DD/YY
Signature **Date**

All amendment requests must include physician's orders and a copy of the PA/RF to be amended.

APPENDIX 13
INSTRUCTIONS FOR THE COMPLETION OF
THE PRIOR AUTHORIZATION DURABLE MEDICAL EQUIPMENT ATTACHMENT (PA/DMEA)

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the Prior Authorization Request Form (PA/RF) and/or the Prior Authorization Durable Medical Equipment Attachment (PA/DMEA) may be addressed to EDS' Telephone/Written Correspondence Unit or Prior Authorization Unit by calling the telephone numbers listed in Appendix 2 of Part A of the WMAP Provider Handbook.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER
Enter the recipient's ten digit medical assistance number exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Enter the age of the recipient in numerical form (i.e., 45, 60, 21, etc.).

PROVIDER INFORMATION:

ELEMENT 6 - PRESCRIBING PHYSICIAN'S NAME
Enter the name of the prescribing physician in this element.

ELEMENT 7 - PRESCRIBING PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit medical assistance provider number of the physician prescribing the item(s) of durable medical equipment.

ELEMENT 8 - DISPENSING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the provider dispensing the requested DME item.

****

The remaining portions of this attachment are to be used to document the justification for the requested DME item(s).

1. Complete elements A through H and J for all items of DME requested except oxygen equipment.

2. Complete elements A through I if request is for oxygen equipment.

3. Attach a photocopy of the physician's prescription to this attachment. The prescription must be signed and dated no earlier than six months prior to receipt by EDS.

4. Read the Prior Authorization Statement before dating and signing the attachment.

5. The attachment must be dated and signed by the provider requesting/dispensing the equipment/item.

APPENDIX 14
SAMPLE PRIOR AUTHORIZATION DURABLE MEDICAL EQUIPMENT ATTACHMENT (PA/DMEA)

Mail To:
E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/DMEA

PRIOR AUTHORIZATION DURABLE MEDICAL EQUIPMENT ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	Ima	A.	1234567890	57

PROVIDER INFORMATION

(6) PRESCRIBING PHYSICIAN'S NAME	(7) PRESCRIBING PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) DISPENSING PROVIDER'S TELEPHONE NUMBER
I.M. Prescribing	87654321	(XXX) XXX - XXXX

A. Describe the overall physical status of the recipient: (mobility, self-care, strength, coordination)

Patient has considerable difficulty with self-ambulation and cannot manage stairs unaided. Mental and physical status is satisfactory.

B. Describe the medical condition of the recipient as it relates to the equipment/item requested — Why does the recipient need this equipment?

Patient is confined to bedroom at night with no bathroom facilities on the same floor. A commode will enable her to remain at home. Denial of this unit will surely cause premature institutionalization.

C. Is the recipient able to operate the equipment/item requested — ☒ Yes ☐ No — If not, who will do this?

D. Is training provided or required? ☐ Yes ☒ No Explain:

E. State where equipment/item will be used:

☒ Home (Describe type of dwelling and accessibility)

Private residence

☐ Nursing Home ☐ School ☐ Office ☐ Job
(Describe accessibility and any special needs)

F. Attach an Occupational or Physical Therapy Report if available.

G. State estimated duration of need: more than 12 months

H. If renewal or continuation of DME Authorization is requested, describe the recipient's
- Current clinical condition
- Progress (improvement; no change, etc.)
- Results
- Recipient's use of equipment/item prescribed

I. Indicate amount of oxygen to be administered:

____ Liters per minute	____ Continuous
____ Hours per day	____ PRN
____ Days per week	____ PaO_2

Attach a photocopy of the Physician's Prescription to this Attachment form. The prescription must be signed and dated within 6 months of receipt by EDS.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J. MM/DD/YY
Date

J. M. Requesting
Requesting Provider's Signature

APPENDIX 15
PROCESS FOR REQUESTING PRIOR AUTHORIZATION AND SUBMITTING CLAIMS FOR DME NONSPECIFIC CODES AND REPAIR CODES

A. Submitting a Prior Authorization Request Form (PA/RF)

1. Include a description of each item with a nonspecific procedure code in sufficient detail to enable the WMAP to set the maximum allowable reimbursement. This must include the manufacturer's item description (e.g., name and model number).

2. Do not include a modifier in element 15 unless modifier "01" is necessary to indicate a bilateral procedure.

3. Always indicate a quantity of "1" in element 19 for nonspecific codes. If requesting two identical items within a non-specific code, identify this as a "pair" in the description or by using a bilateral modifier when allowed. If requesting a series of services, (e.g., serial splints) include the number of splints in the description and quantity of one in element 19. These procedure codes should be billed once per prior authorization number upon completion of service.

4. The Prior Authorization system files have space for up to 12 details. Since the PA/RF has space for only seven details per page, you may submit a two-page PA/RF.

   If you need to group several similar items within a single, nonspecific code to keep within 12 details, the individual items must be individually identified and priced with complete and specific descriptions from the manufacturer on an attachment accompanying the PA/RF. Items such as nuts and bolts may be listed as "hardware."

B. Receiving an Approved PA/RF

1. The maximum allowable reimbursement is indicated for repair and nonspecific procedure codes in element 20. This is initialed and initiated by the state consultant.

C. Submitting Amendments to An Approved PA/RF

1. The only way to obtain a higher level of reimbursement than is identified on the PA/RF for nonspecific codes is by submitting a prior authorization amendment request. An amendment may be submitted if the provider can document that the approved maximum allowable reimbursement does not cover the cost of parts or repairs.

2. If an amended PA/RF is approved after you have received reimbursement, submit an adjustment request for additional reimbursement which indicates that the prior authorization maximum has been changed. Refer to Part A Section IX of the WMAP Provider Handbook for information about adjustment requests.

D. Billing for Nonspecific Codes

1. Use a quantity of "1" to bill for each detail of a nonspecific code.

2. Reimbursement is the billed amount or the amount approved on the PA/RF, whichever is less.

APPENDIX 16
PRIVATE DUTY NURSING AND PERSONAL CARE
ROUNDING GUIDELINES

The following chart illustrates the rules of rounding and gives the appropriate billing unit(s):

Time (in Minutes)	Unit(s) Billed
1 - 30	.5
31 - 44	.5
45 - 60	1.0
61 - 74	1.0
75 - 90	1.5
91 - 104	1.5
105 - 120	2.0
121 - 134	2.0
etc.	